Chichester Chiropractic Health Centre

Insurance Claim Form

Please take a moment to confirm the details of your insurance policy and claim, so that we can submit invoices on your behalf.

Insurance company:	
Policy / membership number:	
Authorisation / claim code:	
Number of sessions approved:	
What is the excess on your policy:	

****Please note – Any Xray imaging taken by Chichester Chiropractic Health Centre cannot be reclaimed via any insurance policy.****

Please read through the following, initial each box to show you have read and understood each point and sign and date at the bottom to give consent.

Insurance Policy and Claim Details:

Regarding private medical insurance claims, Chichester Chiropractic Health Centre is a third-party. This means we are contracted to provide chiropractic services on behalf of your insurance company. As such we do not have access to the full details of your policy and rely on you to contact your insurance company and provide us with the correct details for your claim.

☐ I confirm that I have provided the correct details for my insurance policy, I have spoken to my insurance provider in advance, and that I have been approved for the sessions I am claiming.

Shortfall Payments:

Some private medical insurance policies have an annual excess amount. If you have an excess on your policy, you will be asked to pay this to us directly. If you attend the clinic for any appointments that are not approved by your insurance company, for whatever reason, you will be liable to pay the clinic directly for those visits.

Your insurance company will inform you and us (Chichester Chiropractic Health Centre) of any shortfall payments resulting from your claim. If any insurance claim is denied, you will be liable for our Clinics fee schedule, not that of your insurers. You can find a full price list of services on our website www.chichesterchiropractor.co.uk. For this reason, we require a card on file in order to take payments once they have been confirmed.

☐ I agree to provide the clinic with a securely saved credit or debit card. I understand that should there be any payments due to the clinic, this will be taken from my card on file.

Deposit:

We require a deposit of £48.00 to be held on your account in the event that a claim is denied. At completion of your care this deposit can be refunded or used towards future services.

☐ I agree to pay £48.00 deposit to the clinic. I understand this will be added to my account and held throughout my care. At the completion of my care I can request a refund or can use towards future services.

Print Full Name: ____

Signature: ____ **Date:** _________________________